of public health as well. The aim therefore is to urge those in the private sector of medicine to screen women routinely for asymptomatic gonorrhea.

The techniques used are of utmost importance. Cervical *smears* for gonorrhea screening in women are a waste of time because of poor sensitivity. Bacterial *culture* from a properly secured cervical specimen is the technique of choice. A rectal specimen taken at the same time further enhances the likelihood of identifying asymptomatic carriers.

There are various means of handling these specimens. In general, a modified Thayer-Martin culture plate incubated in a carbon dioxide enriched atmosphere at 35°C is required. One can use standard Petri dishes or smaller modifications. The culture can be sent to an outside laboratory or it can be incubated in a physician's office. Efficient and relatively inexpensive incubators are now available for such use in an office. The plates can be inspected by an office assistant at 48 hours and then tested with a very quick oxidase reagent procedure if colonies of appropriate morphology are noted. Further testing of the oxidase positive material with Gram stain can be done in a physician's office or in an outside laboratory. Sugar fermentation tests can be done to identify the organism more precisely. Another method is to place the specimen immediately in transport media which allows the otherwise relatively labile Neisseria gonorrhea bacteria to be sent to private or health department laboratories during early stages of incubation.

Some physicians would choose to treat a woman purely on the basis of the oxidase positive culture grown on the selective Thayer-Martin medium; some consider it more appropriate to wait for the results of the Gram stain, and some would insist that treatment wait until a diagnosis is made from the full spectrum of laboratory procedures. Under some circumstances, one may wish to repeat a culture that gave positive findings and send it to a clinical laboratory. One's choice in this matter would depend upon social and economic factors as well as upon scientific considerations.

Plates can be purchased and the screening culture test done for less than $1.00 per patient. The added cost of further testing that the physician might choose to do would apply to a very small proportion of the total population being screened. Government funds are available in some communities through local health departments to provide laboratory support for private physicians or clinics. Many local health departments also have trained staff members available to assist with instructions to physicians and their staffs in proper culture techniques.

We make the plea that each physician develop some fairly broad criteria for screening asymptomatic women for gonorrhea by bacterial culture so that this will become common practice.

DAVID D. SACHS, MD
Chairman
California Medical Association
Task Force on Venereal Disease
San Francisco

Is Obesity a Surgical Disease?

THE SPECTRUM OF ILLNESS which confronts us ranges from immediately life-threatening diseases which require bold intervention to cosmetic ailments which trouble primarily the psyche. Massive, often morbid obesity is at neither extreme of this spectrum, and yet it is an illness with potentially lethal complications. Scientists and insurance companies have addressed themselves to the question of where to draw the line between obesity as a disease and inconsequential fatness. We, as physicians, must wrestle with the issue of what posture we should take toward operations which have been devised to combat obesity. Are these operations currently therapeutic or investigational?

The factors and observations which support the operative treatment of obesity have been clearly delineated in recent years.[1,2] Therefore, either to list the positive features of the results from operations as reported by others, or to repeat the statistics of our personal experience, which has been recently reported in some detail[3] would be redundant. It has become abundantly clear that massively obese people who become lean as a result of jejunoileal bypass are usually highly satisfied. Their self-esteem is so enhanced that they gen-

erally become more positive and more productive members of our society than they were before operation. They are frequently so appreciative of the surgeon's successful efforts that they can be counted almost as disciples. When adverse aftereffects require that normal intestinal continuity be restored, the recommendation is usually accepted only with reluctance and patients almost invariably seek an alternative short of returning to their status before jejunoileal bypass. Thus, the positive features of the results are compelling and they should not be underemphasized.

Detracting from the appeal of operations against fatness are the surgical risks and the undesirable delayed sequellae. The latter range in seriousness from annoyance to death, and the nature of the problems which have been encountered is by now generally known.[1-3] Less well known is the degree to which data reported from various centers are comparable, and impossible to quantitate is the depth of follow-up which each report truly represents.

Personal experience leads us to believe that the nature and incidence of the sequellae to jejunoileal bypass are not fully appreciated. For example, our own data can be variably interpreted depending upon whether we chose to report the greater than 90 percent success rate as measured in terms of weight loss and patient satisfaction, or the 43 percent success rate as measured by our more demanding perception as physicians seeking perfection with a large bank of research data available for study. At most recent compilation, more than half of our patients had some sequel to operation (albeit minor in most instances) which would probably not have occurred without operation. Furthermore, we have been consulted more often for complications which have occurred in patients operated upon elsewhere than for complications suffered by our own patients. For instance, three of our patients who needed repeat operation (two shortenings of the bypass and one takedown) had them done elsewhere, and none of the bypasses we have taken down were created by us. Thus, with less compulsive follow-up than is available to us, and reliance upon clinical impression, we could have erroneously concluded that our patients have been immune from problems requiring reoperation. It is abundantly clear that strict and persistent close follow-up for every patient is imperative to truly understanding the nature and the incidence of the sequellae to jejunoileal bypass. It is equally apparent that this type of follow-up is beyond the scope of that which is usual and practical in the office of busy physicians.

Obesity is a surgical disease. We can no longer view fatness in our patients simply as an annoyance which enhances the difficulty of time-tested operations and predisposes to complications. The courage and originality of those who pioneered in devising operations against obesity commands respect. Yet, neither the availability of operations which are successful in causing weight loss, nor the fact that there are plenty of patients who seek them justifies the widespread use of such operations. We should accept obesity as a surgical disease while jealously guarding the perogative to advise against operation. We should condone operations against obesity only under the proper circumstances, and have the fortitude to stand against their being done whenever the circumstances are not appropriate.

The line between therapy and investigation is not always precise. We began 3½ years ago to accept patients for jejunoileal bypass who are part of a carefully conceived series of interdisciplinary research studies, and we have rejected patients who sought operations purely as therapy. Technical operative pitfalls have been minimized and virtually eliminated. Our operative mortality rate of 3 percent and our additional 3 percent mortality from liver dysfunction are reasonable, and our patients are satisfied. However, a previously unreported delayed complication (colonic pseudo-obstruction) has emerged in recent months,[3,4] and we cannot be certain what the future holds even for those of our jejunoileal bypass patients who are currently doing splendidly by all available criteria. Therefore, widespread therapeutic use of jejunoileal bypass against obesity should await better accuracy of prediction than that which is currently possible.

We would suggest that operations against obesity be limited to hospitals prepared to render truly comprehensive care. Recognition of reality precludes recommending that these operations be restricted to clinical study center (CSC) settings, albeit that this remains our conviction. However, the reality that thousands of bypasses have been done outside of CSC settings, neither implies that all operations done without CSC-type of backing were ill-advised, nor does it relieve us of the responsibility to view operations against obesity as investigational at this time. Rather than seek unrealistically and unsuccessfully to stem a tide

which is underway, let us channel it into a useful and constructive stream. Let us recognize the merits of weight reducing operations, but insist that they be permitted only where there is a permanently allied team of physicians and surgeons skilled in the management of obesity and committed to long-term interdisciplinary follow-up which culminates in periodic reporting of results through established professional channels. Let us recognize that anecdotal reporting, either pro or con, is usually misleading, and insist that those willing to take on the operative management of obesity also accept the responsibility for critical indepth analysis of data to be shared with professional peers at a regional or national level. Last, but not least, let us work towards uniformity in criteria for patient selection, and evaluation of results so that today's dilemmas regarding operations against obesity can be expeditiously resolved by summation of comparable data from various centers.

JOHN R. BENFIELD, MD
GEORGE A. BRAY, MD
Departments of Surgery and Medicine
Harbor General Hospital, Torrance
University of California, Los Angeles
School of Medicine

REFERENCES

1. Buchwald H, Varco RL, Moore RB, et al: Intestinal bypass procedures—Partial ileal bypass for obesity. Curr Prob Surg:1-51, Apr 1975

2. Scott HW Jr, Dean R, Shull HG, et al: New considerations in use of jejunoileal bypass in patients with morbid obesity. Ann Surg 177:723-735, 1973

3. Bray GA, Passaro E, Castelnuovo-Tedesco P, et al: Intestinal bypass operation as a treatment for obesity. Ann Intern Med (in press) 1975

4. Fikri E, Cassella PR: Jejunoileal bypass for massive obesity —Results and complications in 52 patients. Ann Surg 179:460-464, 1974

Valuable Clinical Tests for Allergy

THE BRONCHIAL CHALLENGE TEST

. . . The greatest value of a bronchial challenge is when trying to determine which of a group of positive skin tests has clinical significance. And I think bronchial challenge perhaps might be valuable, if any of you have the same problems I have, in dealing with patients who are reluctant to eliminate an animal from their home. I think it would probably be pretty dramatic to have the family in the room and blow a little cat antigen or dog antigen into the child and see the development of asthma. I think even the firmest animal lover would be able to accept this.

—R. G. SLAVIN, MD, *St. Louis*
Extracted from *Audio-Digest Otorhinolaryngology*, Vol 7, No. 22, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1930 Wilshire Blvd., Suite 700, Los Angeles, CA 90057.